

# **SUBCONTRACTOR PRE-QUALIFICATION**

#### 1. SUBCONTRACTOR IDENTITY

| 1a.  |
|--|
| Company Name:  |
| Area of Expertise:   |
| Address:   |
| Phone Number:  |
| Fax Number: Tax ID or SS Number:   |
| Empile   |
| Contact Description  |
| Contact Person(s):   |
| <b>1b.</b> Type of Company (Check Applicable Box): Corporation □ Partnership □ Limited Liability Co. □                   |
| <b>1c.</b> Date Company Formed: Click here to enter a date.  |
| 1d. State of Incorporation:  |
| 1e. Total Number of Employees: a. In Nueces County? B. Outside Nueces County?  |
| 1f. In what state is company legally qualified to do business (Include type and license numbers):                        |
| State: License Number:   |
| 1g. Names and titles of key personnel in company:  |
|  |
|  |
| <b>1h.</b> Has the company operated under any other name in the past five years? Yes □ No □ If yes, give name(s):        |
| <b>1i.</b> Does the company have offices, plants, or warehouses at other locations? Yes □ No □ If yes, give location(s): |
| 1j. How many years has your organization been in business as a contractor under your present business name? Years.       |
| <b>1k.</b> If applicable, what previous names has your firm had in the last five years?                                  |
|  |
|  |
|  |

### 2. FINANCIAL INFORMATION

| 2a.  | Does the company have a line of credit from any lending institution? Yes $\square$ No $\square$ If yes, provide details:  |
|------|---|
|      | Lender's Name: Address: Officer's Name: Phone: Email Address:   |
| 2c.  | State your firm's annual average receipts over the past 3 fiscal years: \$  |
| 3. I | OBE CERTIFICATION   |
| За.  | Is the company a certified, or any other type of certified business enterprise? Yes $\Box$ No $\Box$ If yes, which type?  |
|      |   |
| 4. E | SONDING AND INSURANCE   |
| 4a.  | Do you have the ability to bond projects? Yes $\Box\:$ No $\Box\:$  |
|      | If yes, date of last bonded project:  Single project limit:  Aggregate Limit:  Bonding Company Name & Address:  Point of Contact:   |
| 5. C | OTHER INFORMATION   |
| 5a.  | Has your company or any of its personnel been a party to a bankruptcy or reorganization proceeding? Yes $\square$ No $\square$ If yes, give date:   |
| 5b.  | During the past five years, have any liens been filed against you by any of your subcontractors or suppliers? Yes $\square$ No $\square$ If yes, provide details:                         |
| 5c.  | Have you ever failed to complete a contract, been defaulted, or had a contract terminated? Yes $\square$ No $\square$ If yes, provide dates and details:                                  |
| 5d.  | In the past five years, has your company or any of its key personnel been involved in any lawsuits rising from construction projects? Yes $\square$ No $\square$ If yes, provide details: |

### 6. REFERENCES - Attach extra sheet if necessary

| 6a. | List four (4) previous or ongoing construction projects for whom your firm has provided similar type services as required on this construction project. Provide the name of a contact person for each project, address, zip code, and telephone number who can be contacted to provide reference information on each construction project (Use separate sheet if needed). |
|-----|---|
|     | 1)  |
|     | 2)  |
|     | 3)  |
|     | 4)  |
|     |   |
| 6b. | Trade References (List three of your subcontractors or suppliers; include name, contact, and phone)   |
|     | 1)  |
|     | 2)  |
|     | 3)  |
|     |   |
| 6c. | Client References (List three clients, include name, contact and phone number)  |
|     | 1)  |
|     | 2)  |
|     | 3)  |
|     |   |
| 6d. | Have you or your organization, or any officer or partner thereof, failed to complete a Contract?  Yes □ No □ If yes, give details:  |
| 6e. | List the names of three persons from your firm and their titles who will be assigned to this project:   |
|     | 1)  |
|     | 2)  |
|     | 3)  |
|     |   |
| 6f. | Does your firm maintain a drug free work place? Yes $\square$ No $\square$  |
|     |   |
| 6g. | Does your firm have a quality system? Yes $\square$ No $\square$ If yes, submit a copy of your firm's quality manual.   |
| 6h. | Has company ever been placed on a debarred list? Yes $\square$ No $\square$   |
|     |   |

## 7. SAFETY RECORD 7a. In the past five years, has your company or any of its key personnel been investigated for or found to have committed a serious OSHA violation? Yes $\square$ No $\square$ If yes, provide details: **7b.** What is your current Workman's Compensation EMR rate?: Please attach a copy of current EMR. **7c**. Do you have a written employee safety policy and program? Yes $\square$ No $\square$ 7d. Are there any open or aggregate liability claims that would impair your ability to insure any project? Yes $\square$ No $\square$ If yes, provide details: 7e. Please Submit Current Copy of Insurance Certificate to FDLLC - See page 5 for Example Certificate 7f. Obtain from your Insurance Company(s) your interstate Workers' Compensation Experience Modification Rate (EMR) for the last three (3) rating periods. If you do not have an interstate rating, obtain your intrastate EMR's. **Current Policy Year:** 1 year previously: 2 years previously: To verify the above, please provide one of the following: 1) A certified letter from your insurance company verifying the EMR. 2) A photocopy of the last three (3) year's Experience Rating calculation sheets. 3) A copy of your insurance policy for the last three (3) years that reflects the modification rate and the coverage period. **7f.** Is your firm/company self-insured for Workers Compensation? Yes $\square$ No $\square$ **7g.** OSHA Recordable/Reportable Incidents and Inspection Reports (last 3 years) a. Provide the following items: Copies of your companies OSHA Form 300 and 300A or state equivalent reporting form Number of violations issued by Dept. of Labor (OSHA). Provide explanation type (i.e. willful, serious, de minimis, etc.), penalty assessed, and status. Approximate number of "non-reportable" first aid/one time treatment injuries or incidents. b. 7h. Approximate number of incidents e.g., injuries, fatalities and vehicle accidents involving subcontractor employees while operating on projects you managed 7i. Total number of citations/violations issued by any other federal, state and/or municipal authority including, but not limited to TNRCC, TWCC, City of Corpus Christi, etc. Provide violation date, a brief explanation and current status for each violation. 7i. Provide brief synopsis of your firm's safety education and training programs, safety incentive programs. modified duty and return to work programs and corporate safety team composition and hierarchy.

Contractor hereby warrants that all information supplied pursuant to this form is true, accurate and complete. In the event copies of documents are furnished, contractor warrants that such copies have not been altered in any way from the original document(s). Signed: Date: Title: 500 N. Shoreline Blvd., Suite 500 | Corpus Christi, Texas 78401 | T: 361.288.2900 | F: 361.288.2920 | www.harborbridgeproject.com

| _  |  |   |   |  |                     |  |              |                          |  |
|--|--|---|---|--|---------------------|--|--------------|--------------------------|--|
| ACORD CI   | ER   | ΓIF   | ICATE OF LIAE                                     | BILITY INS   | URANC               | Ε  | 1            | (MM/DD/YYYY)<br>27/2016  |  |
| THIS CERTIFICATE IS ISSUED AS A CERTIFICATE DOES NOT AFFIRMAT BELOW. THIS CERTIFICATE OF INS REPRESENTATIVE OR PRODUCER, A   | IVELY  | OR<br>NCE   | NEGATIVELY AMEND, I<br>DOES NOT CONSTITUTE        | EXTEND OR ALT  | ER THE CO           | VERAGE AFFORDED  | ATE HO       | LDER. THIS<br>E POLICIES |  |
| IMPORTANT: If the certificate holder<br>the terms and conditions of the policy,<br>certificate holder in lieu of such endors | , certa  | ain p   | olicies may require an en                         |  |                     |  |              |                          |  |
| PRODUCER Name of Producer  |  | CONTACT Contact Name of Agent PHONE (A/C, No, Ext): Provide Agent Phone (A/C, No):                                      |   |  |                     |  |              |                          |  |
|  | (A/C, No, Ext): Provide Agent Phone (A/C, No): E-MAIL ADDRESS: Provide Agent Email Address |   |   |  |                     |  |              |                          |  |
|  | -  | INSURER A : Name of   |   | Company  |                     | NAIC#<br>NAIC No.  |              |                          |  |
| INSURED  |  |   |   | INSURER B : Name of  |                     |  |              | NAIC No.                 |  |
| Name of Insured  |  |   |   | INSURER C: Name of Insurance Company (if applicable)             |                     |  |              | NAIC No.                 |  |
| Address<br>Telephone   |  |   |   | INSURER D: Name of Insurance Company (if applicable)             |                     |  |              | NAIC No.                 |  |
|  |  |   |   | INSURER F:   |                     |  |              |                          |  |
| THIS IS TO CERTIFY THAT THE POLICIES   |  |   | NUMBER:   | E BEEN ISSUED TO   | THE INSURE          | REVISION NUMBER  |              | ICY DERIOD               |  |
| INDICATED. NOTWITHSTANDING ANY RE<br>CERTIFICATE MAY BE ISSUED OR MAY<br>EXCLUSIONS AND CONDITIONS OF SUCH                   | EQUIR<br>PERT  | EMEI<br>AIN,  | NT, TERM OR CONDITION OF<br>THE INSURANCE AFFORDE | OF ANY CONTRACT<br>D BY THE POLICIE                              | OR OTHER I          | DOCUMENT WITH RES<br>D HEREIN IS SUBJECT                           | PECT TO      | WHICH THIS               |  |
| INSR<br>LTR TYPE OF INSURANCE  | ADDL<br>INSD   |   | POLICY NUMBER                                     | POLICY EFF<br>(MM/DD/YYYY)                                       | (MM/DD/YYYY)        | L  | MITS         |                          |  |
| CLAIMS-MADE COCUR  |  |   | Enter Policy Number                               |  |                     | EACH OCCURRENCE<br>DAMAGE TO RENTED<br>PREMISES (Ea occurrence)    |              | 00,000                   |  |
|  |  |   |   | Eff. Date  | 5 D.t.              | MED EXP (Any one person)   |              | 00.000                   |  |
| GEN'L AGGREGATE LIMIT APPLIES PER:   | Υ  | Υ   |   | Em. Date   | Exp. Date           | PERSONAL & ADV INJURY  | _            | 00,000<br>00,000         |  |
| POLICY X PROT LOC  |  |   |   |  |                     | PRODUCTS - COMPIOP AG  |              | 00,000                   |  |
| OTHER:   |  |   |   |  |                     |  | \$           |                          |  |
| AUTOMOBILE LIABILITY  ANY AUTO   |  |   | Enter Policy Number                               |  |                     | COMBINED SINGLE LIMIT<br>(Ea accident)<br>BODILY INJURY (Per perso | _            | 00,000                   |  |
| ALL OWNED SCHEDULED AUTOS  | Υ  | Υ   |   | Eff. Date  | Exp. Date           | BODILY INJURY (Per perso   | • •          |                          |  |
| HIRED AUTOS NON-OWNED AUTOS  |  |   |   |  |                     | PROPERTY DAMAGE<br>(Per accident)                                  | \$           |                          |  |
|  | Ш  |   |   |  |                     |  | \$           |                          |  |
| X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE  | γ  | Υ   | Enter Policy Number                               | Eff. Date  | Exp. Date           | AGGREGATE  | *            | 000,000                  |  |
| DED RETENTIONS Amount  |  |   |   |  |                     | AGGREGATE  | \$ 40,       | 000,000                  |  |
| WORKERS COMPENSATION AND EMPLOYERS' LIABILITY  |  |   | Enter Policy Number                               |  |                     | X PER OTH<br>STATUTE ER  | +            |                          |  |
| ANY PROPRIETO RIPARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?   | N/A  | N   |   | Eff. Date  | Exp. Date           | E.L. EACH ACCIDENT   | \$ 500       |                          |  |
| (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below   |  | , 1   |   |  |                     | E.L. DISEASE - EA EMPLO  |              |                          |  |
| DECORA TICKOT CI EXTRONOMENT   |  |   |   |  |                     |  |              |                          |  |
|  |  |   |   |  |                     |  |              |                          |  |
| DESCRIPTION OF OPERATIONS / LOCATIONS / VEHIC  | LES (A   | CORD  | ) 101, Additional Remarks Schedule                | e, may be attached if mo   | re space is requi   | red)   |              |                          |  |
| Project: US 181 Harbor Bridge Project, Corpus Christ   | i, Texa  | 5   |   |  |                     |  |              |                          |  |
| Flatiron/Dragados, LLC, the Texas Department Of Tra<br>Commissioners, and their respective successors, assi                  |  |   |   |  |                     |  |              |                          |  |
| Liability, Automobile Liability and Excess Liability polic<br>Contributory basis as required by written contract. Ex         | des as   | requir  | ed by written contract. The above                 | General Liability and A  | utomobile Liabilit  | y Policies are afforded on a                                       | Primary and  | Non-                     |  |
| contract, with respect to General Liability, Automobile<br>the policies have been endorsed to provide thirty days            | Liabilit   | y, Exc  | ess Liability and Workers' Comper                 | nsation as required by v   | written contract. I | n the event of cancellation t                                      | y the insura |                          |  |
| CERTIFICATE HOLDER   |  |   |   | CANCELLATION   |                     |  |              |                          |  |
| Flatiron/Dragados, LLC   |  |   |   | SHOULD ANY OF THE ABOVE DESCRIBED BOLLOIDS DE CAMOELLES DESCRIBE |                     |  |              |                          |  |
| ATTN: Jenny Janca<br>500 N. Shoreline Blvd., Ste. 500  |  | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN |   |  |                     |  |              |                          |  |
| Corpus Christi, Texas 78401  |  | ACCORDANCE WITH THE POLICY PROVISIONS.  |   |  |                     |  |              |                          |  |
|  | AUTHORIZED REPRESENTATIVE  |   |   |  |                     |  |              |                          |  |
|  |  | Signed by Authorized Representative   |   |  |                     |  |              |                          |  |
|  |  |   |   | Signed by Autho  | rized Repre         | sentative  |              |                          |  |

The undersigned, on behalf of the Subcontractor, certifies under oath that the information provided herein, including any attachment, is true and sufficiently complete so as not to be misleading. Name (Printed):

Signature:

Date:

Title: Please send completed pre-qualification form to Flatiron/Dragados, LLC's Procurement Department:

procurement@harborbridgeproject.com